No. 82-1217

In the Supreme Court of the United States

OCTOBER TERM, 1982

SEYMOUR R. MATANKY, M.D., ET AL., PETITIONERS

v.

UNITED STATES OF AMERICA, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

BRIEF FOR THE RESPONDENTS IN OPPOSITION

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QUESTION PRESENTED

Whether the Court of Claims correctly dismissed petitioner's suit seeking to recover on claims under Part B of the Medicare Program, 42 U.S.C. 1395 *et seq.*

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OPINIONS BELOW

The order of the Court of Claims dismissing the complaint (Pet. App. D-1 to D-3) is unreported.

JURISDICTION

The judgment of the Court of Claims was entered on September 17, 1982 (Pet. App. D-1), and a petition for rehearing was denied on October 22, 1982 (Pet. App. F-1). The petition for a writ of certiorari was filed on January 20, 1983. The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

STATEMENT

1.a. Petitoner Matanky is a physician who provided medical care to individuals insured under Part B of the Medicare Program, 42 U.S.C. (& Supp. IV) 1395 *et seq.*

(Pet. 13).[1] The medical services principally at issue here are visits to patients in nursing homes. The claims of petitioner's patients for reimbursement under Medicare were assigned to petitioner, who then submitted the claims to and received payment from Blue Shield of California. Blue Shield performed the task of evaluating and paying such claims pursuant to a contract with the Secretary of Health and Human Services. 42 U.S.C. (& Supp. IV) 1395u; see *Schweiker* v. *McClure*, 456 U.S. 188, 190-191 (1982). Blue Shield was required by regulations to "[i]nstitute utilization safeguards which include methods for professionally assuring that payments under Part B * * * are for services which are medically necessary" and to take "appropriate action with respect to adjustment or rejection" of a claim for services that were not medically necessary. 20 C.F.R. 405.678(c) (1969); 42 U.S.C. 1395y(a)(1); see *Drennan* v. *Harris*, 606 F.2d 846, 848 (9th Cir. 1970).

In June 1971, petitioner was notified by Blue Shield that the Social Security Administration had requested that future Medicare reimbursements to petitioner be withheld pending an investigation into possible irregularities in the submission of his claims (see Pet. 13-14). In April 1972, a federal grand jury in the Central District of California returned a 46-count indictment charging petitioner with defrauding the United States, in violation of 18 U.S.C. 1001, by submitting false claims to Medicare carriers for visits to patients in nursing homes that he had not made. See *United States* v. *Matanky*, 482 F.2d 1319, 1321 (9th Cir. 1973).

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[1] Petitioner Matanky owns and operates the Corbin Medical Clinic (Pet. App. A-2), which also is a petitioner in this case. The references in the text to "petitioner" are to petitioner Matanky.

Following a three-week trial in October 1972, petitioner was convicted on 39 of the counts in the indictment, the remaining counts having been dismissed on the government's motion (482 F.2d at 1321, 1323). He was sentenced to concurrent three-year terms of imprisonment on each count, execution of which was suspended in favor of one year's probation, and was fined $1,500 on each count, for a total fine of $58,500 (*id.* at 1321; Pet. at 2, *Matanky* v. *United States*, No. 73-334 (1973 Term). The court of appeals affirmed the convictions (482 F.2d at 1321), noting that although petitioner claimed to have visited certain patients two or more times per week, the patients and nursing personnel testified that the visits occurred only once or twice per month (*id.* at 1323). This Court denied certiorari. 414 U.S. 1039 (1973). The government's civil claims against petitioner in connection with the 46 incidents involved in the indictment were settled by agreement with petitioner in the spring of 1974 (R. 131).[2]

b. After matters related to these 46 claims were resolved, the Social Security Administration requested Blue Shield to review other claims submitted by petitioner for visits to patients in nursing homes (R. 131-132). Following an audit of Medicare Part B claims filed by petitioner between 1967 and 1973, Blue Shield determined in August 1975 that petitioner had been overpaid in the amount of $51,316.14 for 2412 claims for services provided to 305 beneficiaries that had not been shown to be medically necessary. Some $1,634.72 in excess of that amount that had been withheld from petitioner was paid to him at that time (Pet. App. A-19; R. 187). On January 22, 1976, petitioner requested that Blue Shield conduct an administrative review of this initial decision—the next stage in the carrier appeals process (R. 190; see *Schweiker* v. *McClure*, *supra*, 456 U.S. at

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[2]"R." refers to the administrative record.

191). On September 30, 1976, after "extensive evaluation" (R. 187), the initial decision regarding the extent of overpayments was affirmed by Blue Shield, with a minor adjustment resulting in the payment of an additional $425 to petitioner (R. 187-189). Four months later, on January 28, 1977, petitioner filed a request for an oral evidentiary hearing by the carrier regarding the remaining claims (R. 183). That hearing was held on August 7, 1978 (Pet. App. G-1), after several postponements.[3]

c. The attorney for Blue Shield stated at the hearing that Blue Shield was not questioning at that time whether petitioner actually made the nursing home visits in question, although the hearing officer reserved the right to question that fact. The sole question to be considered at the hearing was the medical necessity for the visits (Pet. App. G-37 to G-38). Although petitioner testified at the hearing (*id.* at G-30 to G-55), he did not furnish evidence specifically relating to the need for any of the nursing home visits that Blue Shield had determined not to have been medically necessary. Instead, he testified only to his general view that his practice of making two or more visits per week to patients in nursing homes was appropriate (*id.* at G-31 to G-35). Petitioner also testified that he was not aware of certain requirements regarding documentation for nursing home visits because he had left those matters to his office manager (*id.* at G-43, G-51 to G-54).

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[3]The hearing officer informed petitioner that because of the complexity of the case, the hearing would not be scheduled until mid-summer of 1977 (R. 181). The hearing subsequently was set for July 13, 1977 (R. 180), but was rescheduled for August 22, 1977, at petitioner's request (R. 179). Petitioner then sought and was granted a further postponement (R. 173, 174). During this time, petitioner engaged in discovery and apparently suggested settlement of the dispute (R. 169-172). Finally, in response to a suggestion by the hearing officer that the case had been pending "far too long" (R. 159), petitioner requested that the matter be taken off the calendar (R. 157). In April 1978, he requested that another hearing date be set (R. 155), and the hearing then was scheduled for August 7, 1978 (R. 154).

Another witness explained that carriers—when determining what services are medically necessary in the absence of regulations and instructions from HHS—apply the standards of the physician's peers in the community, and that petitioner's claims, when reviewed over a period of time, deviated from those norms (Pet. App. G-86 to G-88). The physician who had conducted the audit of the claims in question testified that there was inadequate documentation in many cases that the nursing home visits were medically necessary (*id.* at G-67 to G-68, G-98 to G-99), especially because the same diagnosis often was repeated for visit after visit without elaboration (*id.* at G-47, G-72; see also *id.* at G-88 to G-89). A representative of Blue Shield explained that Medicare policy reflected in formal guidelines issued in 1970 and 1971 did not bar reimbursement for more than one nursing home visit per month, but required only that an explanation be provided to support the medical necessity of more than one such visit (*id.* at G-75).

d. In October 1978, the hearing officer issued a decision holding that petitioner had been overpaid in the amount of approximately $50,518.22 for uncovered services, and ordered the refund of an additional $371.60 to petitioner (Pet. App. A-26). The hearing officer explained that although petitioner had furnished general information and opinion regarding some details of his practice, he had furnished "no additional information referring to specific claims as required by Medicare ground rules, policies and regulations" (*id.* at A-24 to A-25).

2.a. Petitioner filed an action in the United States District Court for the Central District of California on December 21, 1978, seeking judicial review of the carrier's decision (Pet. App. A-1 to A-14). He asserted that the district court had jurisdiction over his Medicare Part B claims under 42 U.S.C. (Supp. IV) 405(g) (Pet. App. A-2, A-14), even though 42 U.S.C. 1395ff(b) provides for judicial

review of reimbursement claims pursuant to 42 U.S.C. (Supp. IV) 405(g) only under Part A of the Medicare Program. See *United States* v. *Erika, Inc.*, 456 U.S. 201, 207 (1982). The district court transferred the case to the Court of Claims (Pet. 16), in accordance with the prior decision of the United States Court of Appeals for the Ninth Circuit in *Drennan* v. *Harris, supra.*[4] In *Drennan*, the Ninth Circuit had concluded that the district court did not have jurisdiction over Part B claims under either the Medicare Act (42 U.S.C. 405(g)) or 28 U.S.C. 1331, but ordered a transfer of the case to the Court of Claims because that court had ruled in *Whitecliff, Inc.* v. *United States*, 536 F.2d 347 (1976), cert. denied, 430 U.S. 969 (1977), that it had jurisdiction over Medicare cases under the Tucker Act if judicial review was not available elsewhere. 606 F.2d at 849-850.

b. The Court of Claims stayed proceedings in this and a number of similar cases pending this Court's decision in *United States* v. *Erika, Inc., supra*, which presented the question whether the Court of Claims had jurisdiction under the Tucker Act over an action seeking reimbursement for claims under Part B of the Medicare Act. After this Court rendered its decision in *Erika* holding that Congress had foreclosed judicial review of a carrier's determination of the amount, if any, of reimbursement due on a Part B claim, the Court of Claims dismissed petitioner's complaint (Pet. App. D-1 to D-3). The court reasoned that petitioner's challenge to the amount of reimbursement was barred by the decision in *Erika*, and, further, that petitioner's constitutional claims were insubstantial and thus furnished no

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[4] *Drennan* involved a similar reduction by the carrier, after a peer review, in the number of reimbursable monthly visits between 1969 and 1971 by a physician to patients in nursing homes where there was no documentation to establish that more than one visit per month was medically necessary (606 F.2d at 848).

basis for avoiding the jurisdictional holding in *Erika* (*ibid.*).[5]

ARGUMENT

1. This Court held in *United States* v. *Erika, Inc.*, 456 U.S. 201 (1982), that there is no right to judicial review of benefit determinations under Part B of the Medicare Act and that the Court of Claims therefore was without jurisdiction to entertain such a suit. Accordingly, the Court of Claims correctly dismissed this suit for lack of jurisdiction on the authority of *Erika*.

Petitioner seeks to avoid the holding in *Erika* by contending that this case involves constitutional issues and that Congress did not and could not foreclose all judicial review of constitutional questions. Specifically, petitioner alleged in his complaint that Blue Shield violated the Due Process Clause in several respects in its consideration and decision on the reimbursement claims and in its recoupment of the amounts erroneously paid. It is well settled, however, that the Court of Claims does not have jurisdiction under the Tucker Act over an action seeking a monetary recovery for a violation of the Due Process Clause, because that Clause cannot be read to mandate monetary compensation for a violation. See *United States* v. *Hopkins*, 427 U.S. 123, 130 (1976); *United States* v. *Testan*, 424 U.S. 392, 400 (1976). The Court of Claims has specifically so held in the Medicare

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[5]The Court of Claims disposed of petitioner's case in summary fashion, citing to other orders of that court in cases raising similar issues (see Pet. App. D-2). An examination of these other orders makes clear the basis for the Court of Claims' disposition of this case. The Court of Claims also declined to transfer the case back to the District Court for the Central District of of California, in view of the insubstantiality of petitioner's constitutional claims and the Ninth Circuit's decision in *Drennan* v. *Harris, supra*, that district courts do not have jurisdiction over such claims (Pet. App. D-3, citing *Berton Siegel* v. *United States*, No. 119-81C (Ct. Cl. Aug. 20,1982)).

context. *Alabama Hospital Ass'n* v. *United States*, 656 F.2d 606, 609-610 (1981), cert. denied, 456 U.S. 943 (1982); *Regents of the University of Colorado* v. *United States*, No. 518-80C (Ct. Cl. Aug. 27, 1982), slip op. 3-4. Therefore, because jurisdiction over petitioner's statutory claim for reimbursement under Part B was barred, the appending thereto of arguments arising under the Due Process Clause could not serve to vest the Court of Claims with jurisdiction.

2. In any event, as the Court of Claims held, the constitutional claims set forth in petitioner's complaint clearly are insubstantial, especially in the context of this case (Pet. App. D-2). The Court of Claims correctly determined that such wholly insubstantial constitutional claims cannot avoid the jurisdictional holding in *Erika*.

a. As an initial matter, although petitioner framed several of the paragraphs in his complaint in constitutional terms, at bottom his principal contention is simply that the Secretary did not have statutory authority to offset the amount of payments erroneously paid on past claims against the amount that would be due on different, currently pending claims. See Pet. App. A-6 (para. VII), A-8 to A-9 (para. XIII), A-10 to A-11 (paras. XV-XVII), A-12 (paras. XVIII(l) and (3)). This question is one of statutory interpretation, not constitutional right, because it is clear that the Constitution does not bar an agency from recovering, by means of offset, public funds that were improperly paid or expended. See, *e.g. United States* v. *Munsey Trust Co.*, 332 U.S. 234, 239-240 (1947); see generally Brief for the Petitioner, at 15-17, *Bell* v. *New Jersey*, No. 81-2125 (argued Apr. 18, 1983).[6] Thus under *Erika*, the Court of Claims had no jurisdiction to review the carrier's adjustment of the Part B reimbursement claims at issue here.

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[6]We have furnished counsel for petitioner with a copy of the Brief for Petitioner in *Bell* v. *New Jersey*.

Moreover, the right of HHS, through intermediaries and carriers, to exercise the common law right of recoupment by offsetting amounts erroneously paid for services found not to have been covered by Medicare is well established. See *Mt. Sinai Hospital* v. *Weinberger*, 517 F.2d 329 (5th Cir. 1975), cert. denied, 425 U.S. 935 (1976); *Szekely* v. *Florida Medical Ass'n*, 517 F.2d 345 (5th Cir. 1975). As the Fifth Circuit noted in *Szekely* (517 F.2d at 349), the Medicare Act itself, as amended in 1972, expressly recognizes the right to recover funds previously paid to a physician, such as petitioner, who has furnished services and accepted an assignment of a claim from an individual covered by Part B. In 42 U.S.C. 1395u(b)(3)(B)(ii), Congress prohibited a physician from collecting from his patients for services found not to have been covered by Medicare "if the Secretary's determination that payment (pursuant to such assignment) was incorrect * * * was made subsequent to the third year following the year in which notice of such payment was sent to such individual." 42 U.S.C. 1395u(b)(3)(B)(ii); see also 42 U.S.C. 1395cc(a)(1)(B). This provision plainly contemplates that payments that were "incorrect" because the services were not covered by Medicare may be recovered from the physician, even more than three years after they were made.[7] In addition, 42 U.S.C. 1395gg(b)(l)(A) in turn recognizes that excess payments may be recouped from a person who has furnished services under Part A or Part B.

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[7]Given this express statutory ratification of the right of a carrier to recover from a physician on an assigned claim more than three years after payment was made, petitioner's contention in the complaint (Pet. App. A-10 (Para. XV)) that the recoveries in this case were made outside a three-year period of limitations is without merit. In support of this limitations argument, petitioner cited in his complaint a single regulation, 20 C.F.R. 405.1885, that was adopted in 1974. See 39 Fed. Reg. 34515. That provision, now recodified at 42 C.F.R. 405.1885, has no relevance here. It concerns the time period within which a request must be made to reopen a determination by the Provider Reimbursement Review Board regarding the amount to be paid to a provider of

b. Especially against this background, petitioner's contention (Pet. 29-33) that Blue Shield's recoupment of previous payments through offset violated his due process rights because it impaired the obligation of contract is frivolous. As an initial matter, and contrary to the allegations in the complaint (Pet. App. A-8 to A-9 (para. XIII)), petitioner did not have a contractual relationship with Blue

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services under Part A for services that *are* covered by the Act. See 42 U.S.C. 1395*oo*(a)(1)(A). This case, of course, concerns Part B claims and questions of coverage, not the amount of payment for services that are concededly covered.

Petitioner was first notified in June 1971 that his prior claims were being reviewed because of possible irregularities. At that time, regulations applicable to Part B determinations provided that a carrier's decision could be reopened within one year on the carrier's own motion or the motion of a party to the hearing "to allow for correction of a procedural or substantive defect in the proceedings." 20 C.F.R. 405.841 (1971). This provision appears to have been intended for the benefit of the claimant, and it presumably would not have barred all reexaminations of prior determinations—even, *e.g.*, where fraud was alleged. In any event, those regulations were revised in April 1974 to permit reopening for "good cause" within four years from the date of the notice of the prior determination and at any time when the prior determination "was procured by fraud or similar fault of the beneficiary or some other person" (42 C.F.R. 405.841(b) and (c)). Petitioner's conviction on 39 counts of submitting false claims for nursing home visits plainly would constitute "good cause" to reexamine similar claims submitted by petitioner; moreover, in this case, petitioner could be said to have been at fault, warranting a reopening at any time.

Petitioner does not elaborate upon the statute of limitations issue in his certiorari petition. He simply asserts in conclusory fashion (Pet. 38-39) that expansion of a statute of limitations in a way that deprives an individual of substantial property rights violates the Due Process Clause. But even if petitioner were correct that an applicable period of limitations in agency regulations was expanded in this case, it is well established that reinstatement of a remedy after the limitations period has run does not violate due process where, as here, running of the limitations period does not vest a party with substantive rights. See *Chase Securities Corp.* v. *Donaldson*, 325 U.S. 304 (1945), and *Campbell* v. *Holt*, 115 U.S. 620 (1885), upon which petitioner relies (Pet. 39). Cf. *United States* v. *Caceres*, 440 U.S. 741 (1979).

Shield or the Secretary. Whatever right to reimbursement he had derived solely from the assignment of claims to him by participants in the Medicare Part B program. See *United States* v. *Erika, Inc., supra*, 456 U.S. at 207 n.7. The participants in turn have claims to benefits that arise directly under the statute; those benefits are no more contractual in nature than are the benefits paid to participants under other titles of the Social Security Act. See *Weinberger* v. *Salfi*, 422 U.S. 749, 771-772 (1975); *Flemming* v. *Nestor*, 363 U.S. 603, 608-611 (1960); cf. *United States Railroad Retirement Board* v. *Fritz*, 449 U.S. 166, 174 (1980). But even if petitioner were correct that the statute could be said to create implied-in-fact contracts between the Secretary or the carriers and each of the more than 27 million Part B beneficiaries, one of the terms of those contracts would be the provisions in 42 U.S.C. 1395u(b)(3)(B)(ii) and 1395gg(b) that permit recoupment of payments if it is determined that a prior coverage determination was incorrect. See *United States* v. *Erika, Inc., supra*, 456 U.S. at 211 n.14.

Petitioner's contention that Blue Shield's prior adjustment and payment of his claims created a contract by means of accord and satisfaction that could not be impaired through later recoupment is frivolous for much the same reason. Blue Shield acts as a neutral adjudicator, not an adversary, in the payment of claims (*Schweiker* v. *McClure, supra*, 456 U.S. at 195, 197 n.11), and its determination of the amount, if any, of benefits that may be paid on a particular claim therefore no more constitutes an "agreement" of accord and satisfaction between it and the claimant than the judgment of a court creates such an agreement between the court and the litigants. But even if petitioner were correct that the initial payment of benefits constituted some form of agreement of accord and satisfaction, one of the terms of that agreement would be that it is

subject to the adjustment and recoupment provided for under 42 U.S.C. 1395u(b)(3)(B)(ii) and 1395gg(b).

c. The remaining constitutional issue raised in the complaint is that Blue Shield violated due process by failing to provide petitioner with a notice of each individual past claim in dispute or to provide him with an opportunity for a hearing prior to the initial withholding of funds in 1971 or the subsequent recoupment. See Pet. App. A-7 (para. IX), A-9 to A-10 (para. XIV), A-12 to A-13 (paras. XVIII(2) and (4)). These contentions are now moot. After Blue Shield conducted its audit of petitioner's past claims, he was furnished with an itemization of the claims that were being questioned (R. 134-149), and he since has had a hearing on those claims. It is now beside the point whether he should have had more complete notice or a hearing before funds first were withheld in 1971 or before the initial decision by Blue Shield in 1975 that payments in fact had been made for services that were not medically necessary and that the amounts in question would be recouped.

Petitioner also contends in the certiorari petition (Pet. 25-29) that the delay in holding a hearing after funds were withheld in 1971 violated his due process rights. This issue of delay was not specifically raised in the complaint and therefore is not before the Court. In any event, this issue, too, now is moot, since petitioner has had a hearing on the disputed claims. Petitioner does not allege in the complaint or certiorari petition that he was prejudiced by the passage of time prior to the hearing. See *United States* v. *Lovasco*, 431 U.S. 783, 790 (1977).

Moreover, the passage of time in this case was not unreasonable under the circumstances. It plainly was appropriate for Blue Shield, in 1971, to suspend or withhold payments to petitioner until it completed an investigation into possible irregularities on past claims. Petitioner's

indictment and subsequent conviction in 1972 substantiated the need to review his past claims before reimbursing him on new ones. In addition, it was sensible not to institute formal administrative proceedings while the parallel criminal and civil proceedings were pending. Once those proceedings were completed, Blue Shield moved expeditiously to complete an exhaustive audit of several thousand claims, and to review the results of that audit at petitioner's request. Subsequent delays in scheduling the hearing were largely attributable to petitioner (see note 3, *supra*).[8]

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[8]Petitioner briefly asserts (Pet. 4, 15) that due process required that the patients who had assigned their claims to him should have been given notice of the denial of coverage. Apart from the obvious standing problems in raising such a claim, petitioner nowhere alleges or demonstrates that those patients were in any way adversely affected by the recoupment of overpayments from him. Under 42 U.S.C. 1395u(b)(3)(B)(ii), petitioner could not recover from those patients if recoupment was made more than three years after notice of payment was sent to them, if they were without fault in incurring the expenses.

Petitioner also makes a passing assertion (Pet. 30) that reimbursement rules adopted in 1971 were applied retroactively to his case. Contrary to petitioner's contention, however, the Act itself always has permitted payment only for "reasonable and necessary" services. 42 U.S.C. (& Supp. IV) 1395y(a)(1). The guidelines adopted in 1971 simply announced a rule that one visit per month to a nursing home patient would be deemed "reasonable and necessary," while more frequent visits would require documentation. See page 5, *supra*. Moreover, petitioner was aware in 1969 that problems could arise with respect to reimbursement for more than one visit per month. See R. 133 (letter to petitioner from Blue Shield relating to similar policy under Medi-Cal Program).

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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